Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC57000049	A. BUILDING: _____ B. WING _____	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation, Complaint Number 2019001082 and Complaint Number 2019002292 was conducted at Florida Palms Academy Residential Treatment Center for Children and Adolescents Facility on . The facility had deficiencies at the time of the survey.	C 000		
C 200	65E-9.013(3)(a), F.A.C. / - Physician Order (3) Authorization of . . . . or . . . . . . (a) or . . shall be used and continued only pursuant to an order by a board certified or board eligible psychiatrist licensed under Chapter 458, F.S., or licensed physician with specialized training and experience in diagnosing and treating mental . . . . . and who is the child's treatment team physician. If the child's treatment team physician is unavailable, the physician covering for the treatment team physician may meet these qualifications. Physicians allowed to order . . and . . . . . , pursuant to this rule, must be trained in the use of emergency safety interventions prior to ordering them. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to obtain a physician's order from a board certified psychiatrist or licensed physician for the use of a manual . . for 1 of 3 sampled residents (Resident #1). The findings included:	C 200		

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C 200	Continued From page 1 Record review of the RTC's policy titled, " and Manual Policy," dated and revised on , reveals evidence of documentation that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself, staff or others, and non-physical interventions would not be effective and only a board certified psychiatrist or licensed physician can order or . Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . Review of Resident #1's record lacked any evidence of documentation that a physician's order was obtained for a as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed	C 200		

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C 200	Continued From page 2 as per the RTC's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the . . , . . and they sent the resident to the , . In an interview conducted on . . . . at 2:09 PM, Staff F, Floor Manager states the incident happened on . . . . . on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated . . revealed, during morning 15-minute checks of "North Hallway," on . . . . . , ..., Staff E noticed that Resident #1 had visible red marks to the and . . . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 200		
C 208	65E-9.013(3)(i), F.A.C. . . . . / . . . . . - Assessment 1 Hr (3) Authorization of or . (i) Within one hour of the initiation of . . . . or , the ordering physician or other licensed practitioner, as permitted by the state and facility, (including a , , nurse, advanced nurse practitioner, physician assistant,	C 208		

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C 208	Continued From page 3 or registered nurse) trained in the use of emergency safety interventions, shall conduct a [illegible]-to-[illegible] assessment of the physical and [illegible] well being of the child, including: 1. The child's physical and [illegible] status; 2. The child's current behavior; 3. The appropriateness of the intervention measures; and 4. Any physical or [illegible] complications resulting from the intervention. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to conduct a [illegible]-to-[illegible] assessment of the physical and [illegible] well-being of the resident, within one hour of the initiation of [illegible], by a licensed practitioner for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the RTC's policy titled, "[illegible] and Manual [illegible] Policy," dated [illegible] and revised on [illegible], reveals that the use of manual [illegible] is limited to emergencies in which there is imminent risk of an individual physically harming himself, staff or others, and non-physical interventions would not be effective and documents that within one hour of the initiation of a [illegible] a Physician, Registered Nurse (RN) or Advanced Registered Nurse Practitioner (ARNP) must conduct a [illegible]-to-[illegible] assessment of the physical and [illegible] well-being of the resident. Record review reveals Resident #1 was admitted to the facility on [illegible] and discharged on [illegible] with diagnoses that made the resident eligible for	C 208		

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C 208	Continued From page 4	C 208		

the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.
Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night.
Continued review reveals there was no evidence of documentation of a report of
Review of Resident #1's record lacked any evidence of documentation that post assessments were completed with the required 1 hour time frame as required.

In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the RTC's policy.
In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the and they sent the resident to the , .
In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1,

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C 208	Continued From page 5 instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of an undated "correspondence," from Staff H, a RN (Registered Nurse) working on , stating that there was no report of client injuries, or incidents on the 3:00 PM-11:00 PM shift on to the Nursing Department by Staff A. A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 208		
C 210	65E-9.013(4), F.A.C. / - Documentation (4) Documentation. Staff shall document the intervention in the child's record, with documentation completed by the end of each shift during which the intervention begins and continues. Documentation shall include: (a) Each order for or ; (b) The time the emergency safety intervention began and ended; (c) The specific circumstances of the emergency safety situation, the rationale for the type of intervention selected, the less intrusive interventions that were considered or tried and	C 210		

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C 210	Continued From page 6 the results of those interventions; (d) Time-specific assessments of the child's physical and , , condition; (e) The name, position, and credentials of all staff involved in or witnessing the emergency safety intervention; (f) Time and date of notification of the child's parent or guardian and guardian ad litem; (g) The behavioral criteria and assistance provided by staff to help the child meet the criteria for discontinuation of or ; (h) Summary of debriefing of the child with staff; (i) Description of any injuries sustained by the child during or as a result of the or emergency safety intervention and treatment received for those injuries; (j) Review and revise, if necessary, the child's treatment plan, including a description of procedures designed to prevent the future need for and use of or ; and (k) Before or were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical , history of or , , or current use of , , medication that could present a risk to the child and results of such review are documented in the order for or and the child's record. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to document the following information by the end of the shift in which a occurred; the order, the time the intervention began and ended, the time and results of the -to-assessment, the emergency situation that	C 210		

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C 210	Continued From page 7 required the resident to be restrained and the name of staff involved in the emergency safety intervention for the use of a manual . . . . for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the RTC's policy titled, " . . . . . and Manual . . . . Policy," dated and revised on , reveals that the use of manual . . . . . is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others and non-physical interventions would not be effective and that Staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and results of the . . .-to- . . . assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on . . . . and discharged on . . . . with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their . . . . , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and	C 210		

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C 210	Continued From page 8 stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of ..... A review of the "Individual , , Progress Note," dated ..... revealed Resident #1 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that they were restrained three times over the weekend and received several scratch marks. Resident #1 showed the , the marks and explained the events that led up to the ..... , informed Resident #1 that she did not receive notification the resident was restrained." Review of Resident #1's record lacked any evidence that proper documentation was completed, monitoring of the resident was completed and debriefing was completed as required. In an interview conducted on ..... at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " ..... Packet" available for review because it was not completed as per the RTC's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the ..... and they sent the resident to the , . In an interview conducted on ..... at 2:09 PM, Staff F, Floor Manager states the incident happened on ..... on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't	C 210		

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C 210	Continued From page 9 call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 210		
C 214	65E-9.013(7), F.A.C. / - Monitor (7) Monitoring of the child during and immediately after . (a) Staff trained in the use of emergency safety interventions shall be physically present and continually visually assessing and monitoring the physical and well-being of the child and the safe use of throughout the duration of the emergency safety intervention. (b) If the emergency safety situation continues beyond the time limit of the physician's order for the use of , the staff person authorized to receive the verbal order, as identified in paragraph 65E-9.013(4)(c), F.A.C., shall immediately contact the ordering physician to receive further instructions or new orders for the use of and shall document such notification in the child's case file. (c) A physician, or other licensed staff member as identified in paragraph 65E-9.013(4)(i), F.A.C., trained in the use of emergency safety interventions, shall evaluate and record the child's physical condition and	C 214		

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C 214	Continued From page 10 well-being immediately after the [redacted] is removed. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to continually visually assess and monitor the physical and [redacted] well-being of the resident for the safe use of [redacted] throughout the duration of the emergency safety intervention for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, "[redacted] and Manual [redacted] Policy," dated [redacted] and revised on [redacted], reveals that the use of manual [redacted] is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others, and non-physical interventions would not be effective and that Staff trained in the use of emergency safety interventions shall be physically present and continually visually assessing and monitoring the physical and [redacted] well-being of the ... (resident) and the safe use of [redacted] throughout the duration of the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on [redacted] and discharged on [redacted] with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on [redacted] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [redacted], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers,	C 214		

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C 214	Continued From page 11	C 214		

followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.
Further review of the record revealed "Nursing Notes," dated [redacted] at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night.
Continued review reveals there was no evidence of documentation of a report of [redacted].
A review of the "Individual [redacted], Progress Note," dated [redacted] revealed Resident #1 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that he was restrained three times over the weekend and received several scratch marks. Resident #1 showed the [redacted] the marks and explained the events that led up to his [redacted]. [redacted], informed Resident #1 that she did not receive notification the resident was restrained."
Review of Resident #1's record lacked any evidence of documentation that the resident was continually visually assessed and monitored for physical and [redacted] well-being and for the safe use of [redacted] throughout the duration of the emergency safety intervention as required.

In an interview conducted on [redacted] at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no "[redacted] Packet" available for review because it was not completed as per the RTC's policy.
In an interview conducted on [redacted] at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on [redacted], called the Nurse Manager and the [redacted] and they sent the resident to the [redacted].
In an interview conducted on [redacted] at 2:09 PM, Staff F, Floor Manager states the incident

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C 214	Continued From page 12 happened on . . . . . on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated . . . . revealed, during morning 15-minute checks of "North Hallway," on . . . . . , ..., Staff E noticed that Resident #1 had visible red marks to the and . . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . . , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 214		
C 217	65E-9.013(10)(a), F.A.C. Post / - Debrief With Child (10) Post- or practices. (a) After the use of . . . . or . . . . . , staff involved in an emergency safety intervention and the child shall have a . . . -to- . . . discussion, which is also known as a debriefing. Whenever possible, subject to staff scheduling, this discussion shall include all staff involved in the intervention. The child's parent or guardian shall be invited to participate in the discussion. The provider shall conduct the discussion in a language that is understood by the child and the child's parent or guardian. The discussion shall provide both the child and staff the opportunity to discuss the circumstances resulting in the use of	C 217		

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 217	Continued From page 13 . . . . . or . . . . . and strategies to be used by the staff, the child, or others to prevent the need for the future use of . . . . . or . . . . . . The discussion must occur within 24 hours of the emergency intervention, subject to the following exceptions: 1. Allowances may be made to accommodate the schedules of the parent(s) or legal guardian(s) of the child when they request an opportunity to participate in the debriefing and when staff deem their participation appropriate. 2. Allowances may be made to accommodate shift changes, vacation schedules, illnesses, and all applicable federal, state, and local labor laws and regulations. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to conduct a . . . -to- . . . discussion (debriefing) after the use of a with staff involved in an emergency safety intervention and the resident within 24 hours for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated . . . . and revised on . . . . , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others, and non-physical interventions would not be effective and documents that the facility notifies and processes with the parent/guardian of the resident who was restrained and documents the notification and staff person who provided the notification and within 24 hours post the	C 217		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 217	Continued From page 14 staff involved in the intervention and the ... (resident) have a to discussion, which includes the staff involved in the intervention. Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . A review of the "Individual , , Progress Note," dated revealed Resident #1 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that he was restrained three times over the weekend and received several scratch marks. Resident #1 showed the , , the marks and explained the events that led up to his . , , informed Resident #1 that she did not receive notification the resident was restrained." Review of Resident #1's record lacked any evidence of documentation that a -to-discussion (debriefing) after the use of a , was conducted, with staff involved in an emergency safety intervention and the resident within 24 hours as required.	C 217		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 217	Continued From page 15 In an interview conducted on . . . . at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " . . . . Packet" available for review because it was not completed as per the RTC's policy. In an interview conducted on . . . . at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on . . . . ., called the Nurse Manager and the , . and they sent the resident to the , ... In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the . . . and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . . . . ., Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 217		
C 218	65E-9.013(10)(b), F.A.C. Post . . . . /. . . . . - Debrief With Staff	C 218		

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C 218	Continued From page 16 (10) Post- or practices. (b) After the use of or , the staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes a review and discussion of: 1. The emergency safety situation that required the intervention, including a discussion of the factors that caused or preceded the intervention; 2. Alternative, less intrusive techniques that might have prevented the need for the or ; 3. The procedures, if any, that staff are to implement in the future to prevent any recurrence of the use of or ; and 4. The outcome of the intervention, including any injuries that resulted from the use of or and the treatment provided for those injuries. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to conduct a debriefing session after the use of a with staff involved in an emergency safety intervention and appropriate supervisory and administrative staff for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others, and	C 218		

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C 218	Continued From page 17 non-physical interventions would not be effective. ... Within 24 hours, post the staff involved in the intervention as well as appropriate members of the treatment team will conduct a debriefing session. Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . A review of the "Individual , , Progress Note," dated revealed Resident #1 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that he was restrained three times over the weekend and received several scratch marks. Resident #1 showed the , , the marks and explained the events that led up to his . , , informed Resident #1 that she did not receive notification the resident was restrained." Review of Resident #1's record lacked any evidence of documentation that a debriefing session was conducted after the use of a with staff involved in an emergency safety	C 218		

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C 218	Continued From page 18 intervention and appropriate supervisory and administrative staff as required. In an interview conducted on . . . . . at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " . . . . Packet" available for review because it was not completed as per the RTC's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the . . , . . and they sent the resident to the , . In an interview conducted on . . . . . at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated . . revealed, during morning 15-minute checks of "North Hallway," on . . . . . , Staff E noticed that Resident #1 had visible red marks to the and . . . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 218		

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C 219	Continued From page 19	C 219		
C 219	65E-9.013(10)(c), F.A.C. Post / -Debrief Documentatio (10) Post- or practices. (c) Staff shall document in the child's record that both debriefing sessions took place and shall include in that documentation the names of staff present for the debriefing, names of staff excused from the debriefing, and any changes to the child's treatment plan or facility procedures that resulted from the debriefings. This Statute or Rule is not met as evidenced by: Based on review of the Residential Treatment Center for Children and Adolescents (RTC) policy, record review and interview, the RTC failed to follow their own policies and procedures to document in the resident's record that both debriefing sessions took place and included the names of staff present for the debriefing, names of staff excused from the debriefing and any changes to the resident's treatment plan or facility procedures that resulted from the debriefings, for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others, and non-physical interventions would not be effective. ... Staff documents in the resident's record that both debriefings sessions took place and any changes to the resident's treatment plan resulting from debriefing. Record review reveals Resident #1 was admitted	C 219		

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C 219	Continued From page 20 to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . A review of the "Individual , Progress Note," dated revealed Resident #1 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that he was restrained three times over the weekend and received several scratch marks. Resident #1 showed the , the marks and explained the events that led up to his . , informed Resident #1 that she did not receive notification the resident was restrained." Resident #1's record lacked any evidence of documentation that both debriefing sessions took place and included the names of staff present for the debriefing, names of staff excused from the debriefing and any changes to the resident's treatment plan or facility procedures that resulted from the debriefings as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at	C 219		

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C 219	Continued From page 21 the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the RTC's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent the resident to the , In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM- 11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 219		
C 220	65E-9.013(10)(d), F.A.C. Post / - Maintain a Record (10) Post- or practices. (d) The provider shall maintain a record of each emergency safety situation, the interventions	C 220		

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C 220	Continued From page 22 used, and their outcomes. These records shall be maintained in a manner that allows for the collection and analysis of data for agency monitoring and provider performance improvement and shall be available for such purposes upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Residential Treatment Center for Children and Adolescents (RTC) the failed to maintain a record of each emergency safety situation, the interventions used and their outcomes for the use of a manual for 1 of 3 sampled residents (Resident #1). The findings included: Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . A review of the "Individual , , Progress Note," dated revealed Resident #1	C 220		

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C 220	Continued From page 23 stated, "I got restrained three times yesterday and he (Staff A) scratched me a lot." Resident #1 stated that he was restrained three times over the weekend and received several scratch marks. Resident #1 showed the , , the marks and explained the events that led up to his . , , informed Resident #1 that she did not receive notification the resident was restrained." Resident #1's record lacked any evidence of documentation of a record of each emergency safety situation, the interventions used and their outcomes for the use of a manual as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the RTC's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , , and they sent the resident to the , . In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North	C 220		

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C 220	Continued From page 24 Hallway," on . . . . . , ... , Staff E noticed that Resident #1 had visible red marks to the and . . . . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . . . . , Staff A, stated, "I restrained Resident #1 three times last night." Unclassified	C 220		